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ORIGINAL ARTICLE

Psychopathology of hallucinations in schizophrenic patients

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This study addresses the question of hallucinations in schizophrenic patients, with the aim of exploring their qualitative specificities at the phenomenal level of the first-person experience of perceiving.
Three levels of description were explored: the formal features, the content, and the perspective-taking. The formal features addressed were the sense of corporality of the hallucinated "object", the level of sensorial involvement, the perceptual vividness, the perceptual constancy, the spatial localization, and the personification.
From our analysis emerged a very high variability of schizophrenic hallucinations, regarding their form as well as their content. The only formal feature that remains present in all forms of schizophrenic hallucinations is their corporality, which can be reduced but is never absent. For the rest, it is typical but not strictly necessary that they are vague, allusive phenomena. Of the content, more than the themes (persecutory, genealogical, etc.) it was typical the incongruence and the existential aura. Finally, both the implicit an explicit position-taking are severely affected in schizophrenics, with impaired "judgment of reality" and lack of the "awareness of illness". The role of a reduced margin of action in manipulating the experience (including the typical schizophrenic passivity and the experience of givenness), and the global transformation of reality is discussed.
In conclusion, it is remarked that hallucinations can be isolated for practical reasons of study but they are phenomenal emergencies from a complex texture represented by a global transformation of the person's basic structures of experience.

Keywords: Auditory Verbal Hallucinations (AVHs), Hallucinations, Schizophrenia, Pseudohallucinations, Hallucinoses, Phenomenology, Psychosis, Psychopathology

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INTRODUCTION

This is the second study of a project, launched by the Roman Circle of Psychopathology, addressing the issue of hallucinations in general, and the AVHs (Auditory Verbal Hallucinations) in particular. In a previous paper, our group (Maggiora and Aragona, 2020) contested that empirical researchers treat AVHs as if they were basically the same object, independently from being present in normal or pathological conditions and from the kind of disorder of which they are part. Accordingly, we started by showing that AVHs in patients with post-traumatic stress disorder (PTSD) are qualitatively different from the hallucinations usually presented by schizophrenic patients. However, what are the specificities of hallucinations in the latter group of patients? Several studies assessed the prevalence of AVHs in clinical and non-clinical samples (Junginger el al., 1985; Copolov et al., 2004; Nayani et al., 1996; Daalman et al., 2011). From these studies, we know that AVHs are far more frequent in patients with schizophrenic disorder as well as in those with a PTSD. Some formal intrinsic aspects of AVHs were investigated, such as the number of voices, their internal or external origin, the accent, volume and duration, their content (imperative, dialoguing, commenting, echo of thought, teleological, insulting or blasphemous), their meaning (forces of good and evil, conspiracies, ghosts, spirits or aliens), and finally some extrinsic characteristics like coping strategies, degree of insight and distress caused by voices. However, no significant phenomenal differences were found between AVHs in psychotic, affective and traumatic spectrum disorders, and only a few differences were found between AVHs in clinical and non-clinical subjects.

Elsewhere (Maggiora and Aragona, 2020) we claimed that it is the nature itself of the instruments used to study the matter (i.e. checklists, rating scales, etc.) that hampers the

possibility to grasp subtle qualitative differences between similar phenomena. However, such qualitative differences are relevant for a clinical distinction.

This study focuses on hallucinations in schizophrenic patients, addressing the question of their phenomenal characteristics. In theory, two hundred centuries of psychiatry and more than one century of schizophrenia studies should have given us enough information for a complete picture of this phenomenal characterization. However, psychiatric textbooks often differ regarding the number, name and description of the phenomenal characteristics which are relevant in our case while, as stated above, empirical studies often use preformed checklists which are constructed idiosyncratically and do not cover all relevant phenomena.

METHODS

We performed an unstructured opportunistic review of the main textbooks of psychiatry, enriched by psychopathological books focusing on schizophrenia (starting from Bleuler's origins) appeared in Italy in the last century (Bleuler, 1911/1985; Bleuler, 1955/1967; Cassano et al., 1999; Ey et al., 1960/1990; Jaspers, 1913/2012; Jervis, 1975; Kraepelin, 1903/1907; Giberti and Rossi, 2009; Maggini and Sarteschi, 1982; Maj et al., 2010; Mayer-Gross et al:, 1963; Minkowski, 1966/1973; Siracusano et al., 2010; Scharfetter, 1976/1992; Sims et al., 2009) and by selected articles of descriptive and phenomenological psychopathology (Borgna, 1999; Dalle Luche, 2006; Straus, 1956/2001), all addressing the issue of hallucinations.

The descriptions found were then organized according to three main levels of description (formal features, content, and position taking). Because different authors used different terms to indicate same or partially overlapping aspects of the phenomena under study, we decided to use the original term when it was clear and unequivocal, and to rename it when necessary.

Having used personal criteria, we do not claim that the list is complete or that this is the best organization and definition of the phenomenal characterization of hallucinations in schizophrenic patients. It is simply what we consider a possible synthesis of already available descriptions and a starting point for further revision by the community of psychopathologists.

A FEW GENERAL REMARKS

Perceptual process and first-person experience

Epistemologically, we make a distinction between the perceptual *process* and the *experience* of it.

Phenomenological studies on perceptions have opposed the classic empiricist view of perceptions as the product of a bottom-up process of progressive integration of sensorial data, in which the perception is the final output of a peripheral stimulation of sensorial receptors. Indeed, in phenomenology it is widely accepted that, at the level of perceptual *process*, perceiving is not a passive registration of sense data but an active process in which precognitions and attitudes have much to say. Normally we dispose ourselves to perception, prepare ourselves to the encounter with the object, filter and select the appropriate information and, in this way, we give a form to a series of sensorial stimuli that would remain formless without such an activity.

However, at the *experiential* level the person's construction of the experience is hidden and the primary quality of the perceptual *experience* is its immediate sense of the corporality of the perceived object, of its standing there, just in front of the subject, concretely (see below the section on corporality). The person experiences the object without a clear awareness of his own active role in shaping this experience, and this is why at the experiential level we can still talk of *sensoriality* of the experience without assuming that the underlying perceptual process is an empiricist registration of sensorial data.

Single psychopathological phenomena or global transformation?

In general, we share with many phenomenological psychopathologists the belief that hallucinations are part of a wider alteration of the subject's experience, so they have to be studied not only in their intrinsic phenomenal features, but also in a *figure-background relation* with the entire phenomenal picture. This perspective

contrasts a classical view of hallucinations as the perception of something that does not exist in reality. This *realistic* view entails the conception of hallucinations as a specific disorder of perceptions, intruding in a field of consciousness and a personality that remain unaltered, at least at the beginning. In line with this view are those theories, e.g. the cognitive theory of delusions secondary to hallucinations, which support the view that the perceptual disorder is the primary disturbance, and the person's beliefs change as a consequence of it. However, they do not consider that in schizophrenic patients it is the entire way of perceiving themselves, the others and the environment, which are globally altered since the very beginning. In other words, those patients who see a non-existing "little man", see cameras hidden in the walls, or hear voices through the walls, are not just *in front of* a mistake of the perceptual function, they are *immersed* within a global pathological transformation of their experience (Jervis, 1975, p. 230).

In this paper we concentrate on the features of schizophrenic hallucinations, which means that we try to separate hallucinations from the other schizophrenic phenomena which are intertwined in the same clinical picture. For the reasons stated above this is an artificial separation, as will appear clearly as far as the discussion proceeds. Indeed, contextual factors will unavoidably return during the description, confirming that hallucinations are not separate objects that can be simply observed and described, but phenomenal emergencies from a complex texture.

FORMAL FEATURES

Corporality of the lived experience

A first point to be highlighted is that a perception is experienced in a particular way, we could say that it has a peculiar kind of intentionality (in Husserlian terms), which marks the difference between perception and other intentional acts like remembering, imagining, etc.

Put differently, every conscious human being is able to distinguish a given content of his field of consciousness because of its intrinsic experiential quality. Although it may be difficult to say explicitly what is the difference between imagining and perceiving, the experiencing person has an immediate, implicit, *pre-reflexive* understanding of the difference. In psychopathological research, some of these implicit differences can be explicitly formalized, and this is one aim of this study.

A perception immediately refers to an external *corporality*, i.e. to something that stands in front of us in its *concreteness* and *physicality* (Jaspers, 1913/2012, p. 75). In schizophrenic patients, this "perceptual" characteristic is never completely lost (Jaspers, 1913/2012, p. 85; Scharfetter, 1976/1992, pp. 211 et 219). Sometimes the hallucinatory experience is immediately and evidently given as an external object in its actual presence, with the immediacy and freshness that characterizes normal perceptions (although the multisensoriality of normal perceptions is often lacking), and the patient has no doubts that the hallucinated object is given in the surrounding reality. In other cases, which are more frequent, the experience is less clear, evident and fresh (see the section on vividness). In general, in schizophrenic patients we can find different degrees of corporality, ranging from one extreme in which the characteristics are very similar to those of perceptions, to the other extreme in which they are more akin to those of imaginations. However, even in this last case the character of *corporality* is never completely lost. For example, the patient may realize that the hallucinatory experience is different from the other perceptions, and nevertheless he still holds that it is part of the perceptual world, i.e. he sees it as being there, as part of the furniture of the world, despite its possible strangeness.

Sensorial involvement

Multisensoriality

Usually a perception is multisensory, i.e. it is a mixture contemporarily involving at least some of the following senses: sight, hearing, smell, taste, and touch. Moreover, there is a strong relationship between the prevailing sensorial stimulation and the perceptual experience. Of course, hallucinations are by definition experienced without concomitant sensorial stimulation, while regarding the sensorial channels at the level of personal experience (independently from being or not stimulated)

there is wide variability. Some hallucinations are also multisensory, e.g. the reliving of complex traumatic scenes in post-traumatic flashbacks (the patient hearing and seeing the torturer, while perceiving the smell of the jail etc.). Some drug-induced hallucinations are also multi-sensorial experiences, e.g. the LSD trip. In schizophrenia, this possibility is also described, although very often the schizophrenic hallucinations involve only one channel (e.g. the AVHs).

Sensory integration

In normal perception we take information we receive from our senses and integrate and organize it in the perception of a unique object. We contemporarily see and hear a person who is speaking, etc. In schizophrenic hallucinations this often fails: the patient hears the voice but doesn't see the speaker, see someone or something but does not hear the voice/sound, etc.

Perceptual vividness

The object of perception can be more or less vivid and complete, i.e. the sound or the colors can be clear, well defined, complete in their details, experienced with "freshness" and sense of evidence (as something standing there, or clearly present). Jaspers used to differentiate the experience of something objective, with sensorial concreteness and freshness, which is typical of perceptions, and the rougher, pale and faded experience of imagination.

In schizophrenia, the vividness of perception is often altered. Visual hallucinations often present fading objects, or at the opposite enhanced vividness. It also frequent that the object is perceived with only some of its features changed, usually more salient or with an uncanny aura. In these cases, the subject sees "strange", unusual objects, sometimes with blurred and ambiguous forms, incomplete or evanescent images. Auditory hallucinations, particularly voices, are very often altered in various ways: voices like hisses, whistles, with mechanic tones like those of robots, too loud, etc. Usually the voices are ill defined, difficult to distinguish, of uncertain origin, etc. In general, all forms of quantitative and qualitative alterations are possible for schizophrenic AVH.

Despite this patent alteration of perceptual vividness makes schizophrenic hallucinations somehow more akin to representations than perceptions, this is not how the patient experiences them. According to Bleuler (1955/1967, p.41), although in schizophrenia there is a continuum between mere thoughts and representations at one side, and perceptions on the other side, the patients take for granted that they are perceptions. In other words, the hallucinations maintain a "penetrating" force that imposes itself to the mind of the person, independently from the degree of clearness and vividness, i.e. the *corporality* of the lived experience is preserved.

Perceptual constancy

Usually the object of the perception is relatively stable, while the products of imagination tend to fade away and are difficult to be fixed in mind, i.e. they are unstable and mutable.

In schizophrenia, again, there is wide variability: from fixed images which intrude in consciousness with an obsessive-like character, to changing images. Voices are also instable, very rarely they remain the same voice with the same contents. Usually, voices can change in pitch, volume, timbre, tone, etc. without a predictable pattern.

Spatial localization

Externalization

Classic psychopathologists emphasize that while representations are internal, perceptions concern the external space. The perceiving subject is usually directed to something that is in the external space, be it a voice, an image, a smell, etc. When the perception is of a feature of own body, it is the "objective body" (*Körper*) which is addressed, i.e. I see my harm moving, I smell its scent when I put the arm close to my nose, etc. Proprioception is an exception and will be discussed later.

This basic assumption that perceptions involve the external space is problematic in schizophrenia. Although in several cases the hallucinations come from the external space (even though not always from a localizable source), it is also frequent that they come from the

inside (e.g., the voice is speaking in the head, it comes from a single part of the brain, from some body parts, etc.). In the Jaspersian tradition these phenomena are often called pseudohallucinations and are considered more akin to representations, although this distinction is questionable and hallucinations arising in own body are often indistinguishable from external hallucinations. Indeed, in Jaspers' pseudohallucinations the representational character is related to a lack of corporality while, as seen above, hallucinations maintain it.

In other cases, the voices come from the outside but not from the environment. This is the case in which the patient perceives an object outside the normal sensory range (Bleuler's (1903) "extracampine hallucinations"). For example, the person is seen although he is beyond the patient's shoulders, or the sounds and voices come from other worlds, from thousands of miles, etc.

Localization and source recognition

Normally, the distance of the perceived object can vary widely (the voice is heard at a different distance depending from the position of the speaker, etc.), and different subjects are more or less able to localize the "source". In addition, the senses involved make a great difference in the degree of precision in the localization, e.g. the spatial position of an observed object is usually easier to detect than the source of a voice of a person in the dark, or the source of a smell that is spread in the air.

In schizophrenia, it is frequent that the patient is unable to detect the source of the voice, e.g. the place from which the sound is emitted and/or to recognize the source, e.g. hearing a voice without knowing who is talking. In some cases, the patient knows the person who is speaking but does not see him/her in the surrounding environment, etc. Frequently, the voice comes from the neighboring apartment, or from some technical device, or it is a placeless direct mind-to-mind communication.

Proprioceptive localization

Proprioception refers to self-movement and body position. At one side they are perceived in relation to the external space but the perception is somehow internal (referring to own body) and more close to the experience of the "lived body" (*Leib*). According to Wehrle (2020): "In concrete movements, 'knowledge' is part of *being* a body, that is, it is aligned with the body-schema, comprised of proprioceptive information, and which operates automatically in current movements and actions."

In schizophrenia, the disturbances of proprioception are frequent: body parts are perceived as different, often changed or moved from external entities. Here the mixture of lived experience and delusional belief is so strict that it is questionable if the term hallucination can apply. It is interesting that the most "typical" and largely studied proprioceptive hallucinations (i.e., sensation of floating or flying in the absence of a corresponding stimulus) are not so typical in schizophrenia, i.e. they are less frequent and characteristic than in disturbances of consciousness.

Personification

In normal perception, we are able to identify the person who is speaking, the animal producing a vocalization or a specific sound, etc. Sometimes we identify a specific person, animal or device (e.g., my father, my cousin's dog, that car passing by on the street). In other cases, we do not know the speaker personally, but we are able to say her possible age, gender, somatic features, and many other characteristics derived from the automatic integration of contextual information.

In schizophrenia, in some cases personification is preserved, even in AVHs (e.g. "it is that given person who is speaking, although I cannot see her"). However, it is typical of schizophrenic hallucinations that they are often impersonal voices, undetermined sounds, etc. In these cases personification can be completely lost (e.g. "I hear a voice but I cannot say whether the source is a human being or a technological instrument", "I hear a person speaking but I cannot understand whether it pertains to a male or female", etc.).

CONTENT

Almost all contents are possible in schizophrenia, although some are more frequent

and typical. For example, voices often tell the person what she *must* do, force her to perform strange behaviors, comment what she says, reply to what she thinks, and so on. Often the content of these voices is persecutory. Sometimes the voices are denigratory, or they mock and criticize the patient. However, as schizophrenic delusions may have different and overlapping contents, including grandiosity and genealogical ideas, the content of hallucinations may equally be various.

More than the single content, it is more interesting that:

a) In schizophrenia there is often an incongruence between different levels, for example the emotional response and/or the behavior can be different from what expected on the basis of the content of the hallucinations (e.g., a person hears a voice telling him he is going to be poisoned by his mother and nevertheless eats the meal she has prepared). In some cases, different and contrasting contents can be contemporarily present, e.g. voices encouraging and threatening at the same time.

b) The content of schizophrenic hallucinations typically refers to the patient and has an existential importance. For example, Wyrsch (1949/2014) notes that in alcoholics the hallucinations are heard as if a conversation occurring independently from the patient was casually discovered, while in schizophrenia the voices refer directly to the patient, are there for him. Even when they make a conversation in third person, without addressing the patient directly, this is done intentionally, so that he can listen, even indirectly, to the message intended for him. The same author stresses that in alcoholics the content is trivial, a sort of direct externalization of their bad conscience, while in schizophrenics the voices often carry an existential meaning, something deep and concealed.

POSITION TAKING

According to Aragona et al. (*in press*), there are two main kinds of position-taking (*Stellunghname*). As far as the first one is concerned, the immediate, pre-reflexive first-person experience needs to be *formatted* by an implicit and involuntary self-interpretation in order to be grasped and communicated. At a higher level, position taking of the second kind is a more voluntary and explicit search for the meaning of a given experience.

In normal perception, the person is sure that she sees what she sees, that she hears what she hears, etc. In psychopathology, this is considered an impairment of the "judgment of reality", meaning that the person is certain that the objects she perceives are part of the furniture of the world. According to Scharfetter (1976/1992, p. 126), in normal perceptions the certainty of reality is simply given. Although it is used the term "judgment", this attribution of reality to perceptions with a sense of certainty is not a real judgment, as in case of evaluation of pro and cons in order to make a choice. It is something more immediate and implicit, which pertains to the first kind of position taking described above (i.e., the pre-reflexive self-interpretation of first-person experience).

Usually, it is remarked that hallucinations are taken as real by the patients, meaning that they are immediately and passively given in the consciousness of patients, not as constructions but as objective facts. According to Bleuler (1955/1967, p.42), the patients experience an *incontrovertible reality*. However, such "givenness" applies equally to normal perceptions. In other words, as in the case of perceptions, hallucinations are simply "given", i.e. the patient experiences the two phenomena similarly in terms of certainty of their reality.

Here the essence is not that the hallucinations are immediately, passively and without critique perceived as real, because normal perceptions are experienced similarly. What is different is that, while in normal perceptions we experience them passively and nevertheless still maintain a certain degree of freedom, in schizophrenia this margin of action is in question.

Normal perceptions "impose" themselves in consciousness and we cannot decide to start, modify of reproduce them as we like; i.e., they are not at our total disposal. Nonetheless, we can:

a) Redirect our attention, and/or take distance from a disturbing perception and/or try to stop it (e.g., we can close the eyes if a light is excessive).

In some cases the schizophrenic patient behaves similarly, e.g. she can contrast disturbing hallucinations employing strategies similar to those expected in normal perception. However, in other cases the way she tries to oppose them can be frankly bizarre, as in cases in which the patient builds curious devices designed to block the magnetic waves carrying the disturbing voices. In other cases, the patient does not try to defend herself as expected but remains passively exposed.

b) Put them in question when we become aware of some contradiction or perceptual incompleteness (e.g., perceptual illusions can be corrected recurring to their contextualization). Typically and frequently, schizophrenics do not correct their hallucinations when they conflict with the perceptual context. The voices can be unclear, like whispers. The images incomplete in their details, colorless or lacking vividness. The content of hallucinations can be patently absurd. The perceptual integration can be lacking (the voice is heard but nobody is speaking). The source can be strange (from the wall, from within the head). Nevertheless, the patient does not correct his view to acknowledge their inconsistency. On the contrary, it is not rare that, when the hallucination clashes with the perceptual context, it is the latter that is reframed.

We could say that what is characteristic of schizophrenic hallucinations it is not that they are perceived as real, but that *the reality is deeply transformed* to include the viability of hallucinations in the perceptual field.

The second level of position taking concerns the more voluntary and explicit search for the meaning of a given experience. Conscious hermeneutic interpretation is potentially infinite but we can self-confine our present discussion to only one level of the interpretation, i.e. that of the "awareness of illness". It refers to the condition in which a person experiencing a disturbing phenomenon recognizes it as pathological. Sometimes it is also called insight, although the meaning of this last word is more extensive, so we prefer to maintain the former.

Hallucinations are more easily recognized as pathological when they are intrusive, egodystonic phenomena entering in mind against the patient's will, and contemporarily are experienced as a product of the patient's mind. For example, this is the case of the hallucinoses in patients who had used hallucinogens in the past (a possible long-lasting unwanted effect). In such cases, the hallucinatory phenomenon intrudes into the consciousness field and is not integrated in actual experience. It is contemporarily experienced as a foreign body *and* as the product of own mind, and this helps in recognizing it as "pathological" in nature.

In the case of schizophrenia, this possibility is lacking.

First, hallucinations are not recognized as the product of own mind but as something external, and even when the source is internal (e.g., the voice comes from the brain), it is usually experienced as imposed from the external (e.g., the persecutors send messages directly into the brain, from where the voices come). Indeed, many authors talk of a disturbance of "agency" and/or "ownership" to highlight that the schizophrenic does not recognize his AVHs as the product of own mind but as something imposed, with a default attribution of externality.

Second, even when hallucinations are experienced as an unwanted object intruding in the perceptual field, the "foreign body" is imposed from some external entity. Such lack of ownership and externalization of agency makes these phenomena sharply different from obsessive and obsessive-like intrusive phenomena. Accordingly, in schizophrenia the patient's interpretation is not, as it could be, "Something strange is arising in my mind, I'm afraid it's something wrong, a sign of possible disease", but "Somebody is bothering me by sending in my brain unwanted messages", or "The secret services are torturing me with painful rays", etc. In other cases, the hallucinations are not experienced as unwanted intrusive phenomena, they are simply there, in the perceptual field, without any specific reason, and the patient does not question their presence, as if it was normal to see or hear something that the others do not perceive. In both cases, the patient does not concentrate on his/her possible role in the production of these phenomena, so

he/she has no reason to judge them as a sign of illness.

Third, a hallucination can be interpreted as pathological when the patient can acknowledge there is a contradiction between the hallucinated object and the rest of the perceptual field. It is not so common, but in some cases (at least in theory) the unwanted intrusion of an hallucinated object may arise in the perceptual field side-by-side with normal perception. This would make possible to contrast the altered formal features of the hallucination to the unmodified perceptual context, with awareness of the pathological nature of this situation. In schizophrenia this is not the case, because it is the entire perceptual field that is altered, hallucinations being experienced as an integral part of a bizarre lifeworld in which contradictions are blurred. Accordingly, despite their inconsistencies the hallucinations are not recognized as impossible, feeble, incomplete, contradictory, etc. They are taken as they are, as passively experienced without putting in question their plausibility, and consequently the "awareness of their pathological nature" is lacking.

CONCLUSION

This study addressed the question of hallucinations in schizophrenic patients, with the aim of exploring their qualitative specificities at the phenomenal level.

A first distinction was between the *perceptual process* and the first-person *experience of perceiving*. Although it is clear that hallucinations are not mere disturbances of perceptions, it is likely that their definition as "perception without object" is still in use because it is closer to the first-person experiential level: i.e., the patient experiences them with a corporality that is typical of perceptions. It is only at the inferentially richer level of the description of the perceptual process that it becomes clear that hallucinations are not perceptions but implicit personal constructs secondary to more basic disturbances of the way the person experiences himself, his own body, the relationship with the others, his own being-in-the-world.

In this study, we tried to make abstraction from all these complicated and intertwined levels in order to describe hallucinations in themselves. In doing so, we are aware that we abstracted from the global transformation occurring in a schizophrenic experience. However, this is necessary if we want to select a series of explicit, defined features that can be used to distinguish schizophrenic hallucinations from other hallucinatory phenomena reported in other conditions.

We organized the qualitative characteristics of hallucinations in three main levels of description: the formal features, the content, and the perspective taking.

The formal features addressed were the sense of corporality of the hallucinated "object", the level of sensorial involvement (including the mono- or multi-sensoriality of the experience and the degree of sensory integration), the perceptual vividness, the perceptual constancy, the spatial localization (we treated separately the externalization of the "object", the patient's capability to localize it and detect its source, and the proprioceptive localization), the personification (i.e. the ability to identify the identity of the hallucinated "object" or of its source, or at least its peculiar characteristics like age, gender, etc.). From our analysis emerged a very high variability of schizophrenic hallucinations, which are only in a few cases well-defined, vivid, with appropriate detection of the source and good personification. It is more frequent that they are sensorially incomplete, lack vividness, with limited or absent personification, scarcely localized, etc. It seems that the only formal feature that remains present in all forms of schizophrenic hallucinations is their corporality, which can be reduced but is never absent. For the rest, it is quite typical that they are vague, allusive phenomena, but this is not a rule.

Also regarding content, although some issues are more frequently presented in schizophrenics, we found a very high variability of contents. More than the theme, it was more typical the incongruence and the existential aura.

Finally, both the implicit an explicit position taking are severely affected in schizophrenics. Despite the hallucinations are frequently strange, incomplete, in contrast with the perceptual field, etc., the patients are sure of their reality

as if they were normal perceptions. We stressed that in the implicit position-taken the difference between perceptions and hallucinations is not in the subjective certainty of reality but in the reduced margin of action and in the global transformation of reality. Indeed, the point is not that the patient experiences hallucinations as if they were real perceptions, but that their *lived* reality is deeply transformed to allow the inclusion in its field of bizarre phenomena like many hallucinations. Regarding a more explicit position taking, there is a lack of "awareness of illness", i.e. the patient does not recognize the hallucinations as pathological. As shown, the patient does not identify the hallucinations as a product of her mind, experiences them passively without questioning their presence, ad does not realize that they are in contradiction with the surrounding reality, leading to the typical failure to perceive them as pathological in nature.

In conclusion, it must be emphasized that we tried to distinguish the descriptive features of hallucinations as if they were objects. It was necessary as a preliminary step in the process of the construction of assessment instruments more sensible than the rating scales currently in use to the qualitative differences among phenomena. This should enhance their discriminating ability in future empirical studies, avoiding artefactual results like the current confusion between hallucinations, hallucinoses and related phenomena. However, considering this as a necessary step does not entail the belief that hallucinations are isolated objects. Quite the opposite, we think that in schizophrenic patients there is a global transformation of their basic structures of experience and that hallucinations are part of it and can be separated only as an abstraction of phenomenal emergencies from a complex texture.

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